Approved
11/20/18
SHN

Hartford Hospital
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November 14, 2018

Susan Newton, RN, BS
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of Connecticut - Department of Public Health
410 Capitol Avenue
MS# 12 FLIS P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Newton,

Attached please find our Plan of Correction for the October 18, 2018 Statement of Deficiencies for the onsite visit concluding on September 17, 2018 by representatives of State of Connecticut, Department of Public Health.

We believe we've addressed each violation with a comprehensive plan of correction which includes all required components. Should you have any questions on the contents, please contact Cheryl Ficara, RN, MSN, Vice President of Patient Care Services at 860-545-3217.

Sincerely,

Bimal Patel
President, Hartford Hospital
Senior Vice President, Hartford HealthCare

SM:kk
Attachment(s)

Hartford Hospital

DPH Plan of Correction Survey Ending 9/17/2018

Violations 1 a and b:

The Hospital's Pain Management Policy and the ED's Documentation Guidelines were reviewed and found sufficient to address the identified issues. The violations will be reviewed with all ED nurses with reeducation on the requirements for pain assessment/reassessment frequency, including prior to discharge, and documentation of same – by November 30, 2018.

Documentation of pain assessment and reassessment, when indicated, will be audited monthly for three months, November 2018 through January 2019 or ongoing based upon performance results.

Documentation of pain assessment and reassessment will also be monitored concurrently on a random daily basis to provide immediate feedback to individual nurses on compliance with requirements – monthly for three months, November 2018 through January 2019 or ongoing based upon performance results.

Inpatient staff nurses will also be reeducated on the documentation requirements for pain assessment and reassessment via the department – wide Nursing Newsletter – by December 15, 2018.

Documentation of pain assessment and reassessment will be monitored monthly by Pain Resource Nurses for three months, November 2018 through January 2019 or ongoing based upon results

The Nurse Director of the Emergency Department is responsible for this plan of correction.

Violation 2 a:

The Hospital's Pain Management Policy and the ED's Documentation Guidelines were reviewed and found sufficient to address the identified issues. The violations will be reviewed with all ED nurses with reeducation on the requirements for pain assessment/reassessment frequency, including prior to discharge, and documentation of same – by November 30, 2018.

Documentation of pain assessment and reassessment, when indicated, will be audited monthly for three months, November 2018 through January 2019 or ongoing based upon performance results.

Documentation of pain assessment and reassessment will also be monitored concurrently on a random daily basis to provide immediate feedback to individual nurses on compliance with requirements – monthly for three months, November 2018 through January 2019 or ongoing based upon performance results.

Inpatient staff nurses will also be reeducated on the documentation requirements for pain assessment and reassessment via the department – wide Nursing Newsletter – by December 15, 2018.

Documentation of pain assessment and reassessment will be monitored monthly by Pain Resource Nurses for three months, November 2018 through January 2019 or ongoing based upon results

This violation will be reviewed with ED nurses and PA/APRN staff with reeducation on the need to provide alternative pain interventions when indicated – by November 30, 2018.

Documentation of alternative/additional pain interventions when pain reassessments indicate ineffectiveness of the initial intervention will be monitored monthly for three months, December 2018 through February 2019.

The Nurse Director of the Emergency Department is responsible for this plan of correction.

Violations 3 a and b:

The IV catheter policy was reviewed and found to be sufficient to address the issues in this violation.

This violation will be reviewed with ED nurses and nurses on the identified surgical unit with reeducation on the need for IV site assessment and documentation of same, and documentation upon removal of an IV – by December 17, 2018.

Documentation of IV site assessment and removal of an IV will be monitored monthly for three months, December 2018 through February 2019.

The Nurse Directors of the Emergency Department and Surgery are responsible for this plan of correction.

The Hospital is in the process of centralizing IV insertions on all inpatient units, excluding the Critical Care and Labor and Delivery units. This will ensure the accurate and timely documentation of all peripheral IV insertions and removals (during hospitalization), including required site assessments and reasons for removal. Unit staff nurses will be educated to their role regarding IV catheters in this new centralized process. Pilot to be completed on one inpatient medical unit by January 1, 2019.

The Nurse Manager of IV Therapy is responsible for this plan.

Violation 4 a:

This patient's complaints occurred from dates of service in 2016 and the process for managing patient complaints and grievances was reviewed after these dates and subsequently revised as follows:

A revised Complaint and Grievance Management Policy was approved and implemented at all Hartford Health Care Hospitals, effective 9/12/2017.

A Complaint and Grievances Information Packet was developed for staff in the "Office of Patient and Family Affairs (Patient Advocacy)" to ensure consistency in their internal procedures of documenting (e.g. "logging in process") and follow up to complaints and grievances, effective 9/12/2017. Effective 10/10/2017, the office has been administratively reassigned to the Department of Healthcare Consumer Engagement.

The structure of the Office of Patient and Family Affairs (Patient Advocacy) was reviewed and revised to include the hire of a Nurse System Manager on 5/30/2017 to provide appropriate clinical oversight to the office staff and the complaint/grievance management process.

Regional Hartford Health Care multidisciplinary grievance committees were implemented, meeting monthly to review prior month's complaints and grievances and to identify any issues for resolution or escalation. Hartford Hospital's grievance committee was implemented in November 2016 – membership was reviewed and revised in August 2017. A Weekly report of the status of current complaints and grievances ("Administrative File") was implemented on 7/7/2017. The report is forwarded to the VP Patient Care Services, Risk Management Director, and Regulatory Director for review and escalation of any action identified for prompt resolution.

Nurse Managers and Nurse Directors were educated to revisions in the complaint and grievance management process on 7/7/2017. Mandatory annual education of hospital staff on

the complaint and grievance management process was implemented via our on line learning system, Health Stream by 12/4/2017. The System Director, Office of Experience/Healthcare Consumer Engagement is responsible for this plan of correction. Completion date 12/4/2017. Monitoring of status and resolution of complaints and grievances is monitored on a weekly basis – ongoing.

Violation 5 a:

The Case Coordination Discharge Planning policy was reviewed and found sufficient to address the issues in this violation. To ensure that the patient's transition plan is reassessed and appropriate on the day of transition/discharge, a Patient Transition Checklist for Nursing will be developed and will specifically include a confirmation that the transportation mode remains safe and appropriate based on the patient's current clinical and functional status – by December 14, 2018.

Inpatient staff nurses and nurse managers, and Case Coordinators assigned to inpatient units will be educated to the use of the Checklist – by December 21, 2018.

A pocket sized card of the Patient Transition Checklist will also be developed as resource – by December 21, 2018.

The transport of patients via taxi service at the time of transition will be audited for appropriateness based upon patient's independence in ambulation, need for assistive devices, and the availability of assistance upon arrival to the patient's destination – monthly for three months, December 2018 through February 2019 or ongoing based upon results.

The Director of Case Coordination is responsible for this plan of correction.

Violation 6 a:

The ED's Documentation Guidelines were reviewed and found sufficient to address the identified issues. The violations will be reviewed with all ED nurses with reeducation on the following: nursing assessment frequency, including prior to discharge, and documentation of same; respiratory assessment and/or response following each oxygen titration and documentation of same – by November 30, 2018.

Documentation of nursing assessment, oxygen titration and corresponding respiratory assessment will be audited monthly for three months, November 2018 through January 2019 or ongoing based upon performance results.

The Nurse Director of the Emergency Department is responsible for this plan of correction.

Violation 6 b:

The Respiratory Therapy Department nebulizer procedure was reviewed and found sufficient to address the identified issues. The identified respiratory therapist was counseled and reeducated on the requirements to document an assessment/patient response following a treatment – by September 1, 2018.

Respiratory therapy practitioners were informed of this violation and reeducated to the required documentation following a nebulizer treatment – by September 1, 2018.

Documentation of respiratory therapy assessment/patient response following a nebulizer treatment will be audited monthly for three months, August through October 2018 or ongoing based upon performance results.

The Manager of Respiratory Care is responsible for this plan of correction.

Violation 7 a:

The APRN and Physician Assistant work groups will be informed of this violation and the medical record documentation guidelines to verify the identity of the patient prior to authenticating as final any entry into the medical record – by December 17, 2018.

Through our on line incident reporting system, medical record documentation errors related to patient identification will be monitored on an ongoing basis to identify opportunities for improvement – ongoing beginning November 2018.

The Director Regulatory Readiness is responsible for this plan of correction.

Violation 8 a:

The identified staff nurse was counseled and reeducated on the medical record documentation guidelines for correcting hand written entries in the medical record – by September 1, 2018.

Inpatient staff nurses will be informed of this violation and reeducated on the medical record documentation guidelines for correcting hand written entries in the medical record – by December 15, 2018.

Documentation on the Rapid Response flow sheet will be audited for accuracy of entries and appropriate documentation corrections - monthly for three months, November 2018 through January 2019.

The hospital is exploring the use of narrator functionality to capture real time documentation during emergency medical events.

The Director Quality and Safety is responsible for this plan of correction.

Violation 9 a:

Management of respiratory emergencies in patients with tracheostomies is being reviewed through collaboration with the Departments of Anesthesia, Otolaryngology, and Nursing in order to identify best practices for interventions and patient monitoring.

The policy for care of the patient with a tracheostomy has been reviewed and will be revised – by December 15, 2018.

A "Difficult Airway" algorithm will be developed, identifying assessments and interventions based upon scope of practice – by January 15, 2019

A "Difficult Airway" interdisciplinary response team (DART) will be established to respond to tracheostomy-related emergencies – by January 15, 2019

Inpatient nurses and medical staff will be educated to these changes in the management of respiratory emergencies – by February 15, 2019

The appropriate response to respiratory emergencies in patients with tracheostomies will be monitored monthly for at three months February 2019 through April 2019 or ongoing based upon performance results.

The Manager Respiratory Care is responsible for this plan of correction.

Violation 10 a:

Emergency Department and inpatient nurses and physicians will be reeducated to the Hartford Health Care system policy on patient personal representatives – by December 15, 2018

Emergency Department and inpatient nurses will be reeducated to the process of documenting a legal representative in the electronic medical record (EMR) and the presence of a banner in the EMR as a visual reminder – by December 15, 2018.

Emergency Department physicians will be reminded to escalate discharge planning issues to the Social Work or Case Coordination Departments – by December 15, 2018.

Documentation of notification of/communication with conservators of identified patients will be monitored monthly for three months, December 2018 through February 2019 or ongoing based upon performance results.

The Director Social Work is responsible for this plan of correction.

Violation 11 a:

The hospital policies regarding pressure ulcer prevention and treatment were reviewed and found sufficient to address issues identified in this violation.

Staff nurses on the identified medicine units will be informed of this violation and reeducated to the pressure ulcer prevention and treatment policies and procedures – by December 15, 2018.

Documentation of assessment of pressure injuries including wound measurements, dressing changes and the use of pressure reducing devices including waffle cushions will be audited monthly for three months, December 2018 through February 2019 or ongoing based upon performance results.

The Medicine Unit Nurse Manager is responsible for this plan of correction.

Violation 12 a:

The assigned PCA (COIN observer) was immediately counseled by the nurse director, including reeducation on the role of the continuous observer – by August 1, 2018

Emergency Department nurse and PCA staff were reeducated to the role of the continuous observer and safety expectations when a patient is placed on continuous observation – by August 31, 2018

A continuous observation audit tool was developed to monitor compliance with safety expectations – monthly for three months, August through November 2018 or ongoing based upon results.

The Emergency Department Nurse Director is responsible for this plan of correction.